United States Senate

Republican Policy Committee

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The Specialty Hospital Debate: One Year Later

Additional Review Yields the Same Conclusion . . . Specialty Hospitals Have a Role to Play in the Delivery of High Quality Care

Executive Summary

- All hospitals (whether they be teaching hospitals, community hospitals, specialty hospitals, or otherwise) play an important role in the delivery of quality care. The priority for Congress and for hospital groups should be ensuring that all hospitals receive fair reimbursement for the care they provide.
- The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) imposed an 18-month moratorium on the referral of Medicare patients to new, physician-owned "specialty hospitals." That moratorium was scheduled to expire on June 8, 2005, but was later extended to allow for additional studies.
- Congress (in the Deficit Reduction Act of 2005) mandated the extension until at least August 8, 2006, pending the submission of updated reports from the Secretary of Health and Human Services (HHS) and the Medicare Payment Advisory Commission (MedPAC). These reports are to provide Congress with additional data to review in determining how to proceed with this issue.
- In the meantime, HHS is working on administrative changes to the rules used to reimburse all hospitals for the care they provide to Medicare patients.
- The process used to reimburse hospitals under Medicare is critically flawed. Changes to the rules, recommended last year by both MedPAC and HHS, will ensure that specialty hospitals do not take unfair advantage of irregularities in the payment rules.
- Recent data collected by HHS, MedPAC, and the Government Accountability Office (GAO) demonstrate that little has changed since 2005, when it was found that specialty hospitals posed no negative impact on their neighboring community hospitals.
- Community hospitals remain concerned that specialty hospitals represent unfair competition in the marketplace. Specialty hospitals counter that they provide patients with an additional option for high-quality care.
- Fair and adequate reimbursement should be achievable for all hospitals without excluding any one group of providers from the marketplace.

Introduction

For hospitals and physicians, there has been an ongoing struggle to obtain fair and adequate Medicare reimbursement for the costs of providing health care services. Over the last several years, a divide has been growing within the hospital community as an increasingly diverse group of providers vies for the same compensation dollars. In particular, debate has centered on the growing rift between full-service community hospitals and more narrowly-focused specialty hospitals. This debate has distracted from what *should be* the shared goal of improving the quality of care for patients at adequate reimbursement rates.

Reimbursement for care need not be a zero-sum situation. All hospitals (whether they be teaching hospitals, community hospitals, specialty hospitals, or otherwise) play an important role in the delivery of quality care. The priority for Congress and for hospital groups should be to ensure that *all* hospitals receive fair reimbursement for the quality care they provide, without excluding any one group of providers from the marketplace.

Context of the Specialty Hospital Debate

Specialized, targeted-care facilities, like women's and children's hospitals, are not new to medicine. However, the recent, rapid growth of certain specialized facilities owned by physicians represents a relatively new trend. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) contained a little-known provision imposing an 18-month moratorium on the referral of Medicare patients to new, physician-owned "specialty hospitals." That moratorium expired on June 8, 2005.[1]

In particular, the MMA focused on specialty hospitals that primarily provide care to Medicare patients in cardiac care, orthopedics, or surgery, and how the success of these facilities might affect the financial well-being of community hospitals.[2] In order to determine whether additional legislative or administrative restrictions on specialty hospitals were necessary, Congress required the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS) to review the issue.[3] After Congress received the MedPAC and HHS reports in March and May of 2005, the moratorium was allowed to expire. Even so, HHS continued to enforce certain restrictions on the development of new specialty hospitals, pending updated studies from both HHS and MedPAC. Congress (in the Deficit Reduction Act of 2005) mandated that the restrictions continue to be enforced until at least August 8, 2006, when the final report from HHS is due to Congress. An interim report was submitted on May 9.[4] The additional studies will assess more recent data from a larger number of hospitals than were examined in the 2005 studies. In addition to the reports from HHS and

[1] Section 507 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173, H.R. 1, 108th Congress, 1st Session, December 8, 2003 (hereafter referred to as MMA).
[2] MMA, Section 507(a)(1)(B).
[3] MMA, Section 507(c).
[4] Section 5006 of the Deficit Reduction Act of 2005, Public Law 109-171, S. 1932, 109th Congress, 2nd Session, February 8, 2006.

MedPAC, the Government Accountability Office (GAO) has submitted a report to the House Ways and Means Committee that provides information about whether competition from specialty hospitals changes the behavior of community hospitals.

The Republican Policy Committee published a detailed discussion of the specialty hospital debate as it related to MMA in a May 23, 2005, paper titled, "*The Specialty Hospital Debate: Beyond the Medicare Moratorium*." [5] That paper is attached for reference and provides relevant background for this paper, which examines the updated information being submitted to Congress. That paper also compares the arguments for and against further restriction of the growth of physician-owned specialty hospitals and provides a brief update on the status of recommendations made by MedPAC and HHS in their 2005 reports regarding reform of the Medicare payment system.

Summary of Recent Debate

Congressional debate about Medicare reform in 2003 included discussion of concerns, voiced by the nation's community hospitals, related to the increased prevalence of physician-owned specialty hospitals in the marketplace.

Quality of Care

In general, community hospitals feared that the competition posed by specialty hospitals would interfere with their ability to offer quality care to all of their patients. As with physician reimbursement, hospital reimbursement remains an extremely important issue. As budget dollars are spread ever thinner, Congress must ensure that the nation's best providers are being properly compensated and that special attention be focused on identifying why some providers may be underperforming. The nation's hospitals face enormous pressures in seeking to provide the highest quality care to their patients. However, in their 2005 reports to Congress, neither HHS nor MedPAC identified any major problems that specialty hospitals posed to community hospitals. In its report, HHS, which was charged primarily with studying the quality of patient care, noted that "cardiac hospitals delivered high quality of care that was as good as or better than their competitor hospitals."[6] The agency also reported an "extremely high" level of patient satisfaction.[7] MedPAC, focusing on the financial implications of specialty hospitals in the marketplace, reported that "those community hospitals competing with specialty hospitals have demonstrated financial performance comparable to other community hospitals."[8]

[5] The paper is attached and is also available at http://rpc.senate.gov/_files/May2305SpecHospJS.pdf.
[6] CMS, "Centers for Medicare & Medicaid Services Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," May 2005, p.42 and p.iii.
[7] CMS, p.iii.
[8] MedPAC, "MedPAC Report to the Congress: Physician-Owned Specialty Hospitals," March 2005, p.vii.

Payment System Problems

Observers on both sides of the issue – those who supported specialty hospitals and those who did not – seemed to agree on one point: the process used to reimburse hospitals for the care they provide to Medicare patients is critically flawed. That reimbursement process, the Medicare Inpatient Prospective Payment System (IPPS), implicitly encourages "cherry-picking" (i.e., patient selection based on profitability) because of the method it uses to determine payments to hospitals for inpatient stays. This method categorizes payments using "diagnosis-related groups," known as DRGs, that (as currently formulated) have proven to be inaccurate in measuring costs. DRGs are used to classify Medicare hospital inpatients for payment purposes, based on their medical diagnosis and the procedures that will be performed during their stay. The DRGs are then used as part of a complex, multi-factor payment formula to determine how much a hospital will be reimbursed for care of a particular patient.[9]

According to MedPAC, "discrepancies between Medicare's payment rates and hospitals' average costs per discharge across DRGs result in differences in profitability. These profitability differences create financial incentives – for all hospitals, *specialty and nonspecialty alike* – to specialize in treating relatively profitable DRGs."[10] MedPAC further noted that "when DRGs are defined too broadly they fail to isolate differences in severity of illness that substantially affect the cost of hospital inpatient care. The resulting differences in profitability *within* DRGs create financial incentives for hospitals to select relatively low-cost patients, such as those who have the same diagnosis but are less severely ill."[11] Ultimately, both MedPAC and HHS recommended changes to the IPPS, including changes specific to DRGs.

Definition of "Hospital"

Another issue has been the definition of "hospital" for the purposes of Medicare reimbursement under Section 1861(e) of the Social Security Act.[12] In general, the law prohibits physicians from referring patients to entities in which the physician has an ownership interest. Congress enacted an important exception to this law that allows referrals to a "whole hospital." That is, a physician may refer patients to a whole hospital in which he has an ownership interest (as opposed to a single department of the hospital), since the referrals are not likely to influence the profitability of that physician's personal investment. Critics of specialty hospitals argue that specialty hospitals are not whole hospitals as contemplated by the law and, therefore, are exploiting this exception. Furthermore, one of the key requirements for a hospital under this section is that it be primarily engaged in treating patients in an inpatient setting.

In its 2005 report, HHS found that some specialty hospitals (namely orthopedic and surgical hospitals) more closely resemble ambulatory surgical centers (ASCs) than other hospitals because their business relies heavily on outpatient services. Payments for hospital outpatient procedures under the Outpatient Prospective Payment System are typically higher than payments for the same services provided in an ASC. As a result, critics contend that some

[9] See pages 7-8 of the 2005 RPC Policy Paper for greater discussion of this issue.
[10] MedPAC, p.25 (emphasis added).
[11] MedPAC, p.26 (emphasis added).
[12] See 42 U.S.C. 1395x.

specialty hospitals may be holding themselves out as whole hospitals in order to exploit the difference in payments.

In the end, critics argued that payment reforms would not go far enough in limiting the growth of specialty hospitals. They suggested that collecting and reviewing additional, more recent data would uncover larger problems that would justify more stringent regulation of specialty hospitals or, possibly, a complete ban on specialty hospitals within the Medicare program.

Some of the payment issues being evaluated by HHS and MedPAC are technically complex and may be difficult to understand at first glance. Please refer to the attached paper for additional background information that may make these issues easier to understand.

New Data Underscores Previous Data

A full year has passed since the June 8, 2005, expiration of the specialty hospital moratorium mandated by the MMA. In that time, HHS, MedPAC, and GAO have been studying additional data that were not available when the issue was first presented to Congress. Larger sample sizes and additional years of Medicare claims data bring the specialty hospital issue into clearer focus; however, the fundamental findings reported last year remain unchanged. That is, additional data suggest that specialty hospitals provide patients with additional options and quality care without significantly affecting the community hospitals with which they compete.

HHS Interim Report (May 9, 2006): Consistent with 2005 Results

In its interim report, mandated by the Deficit Reduction Act, HHS provided nothing that would fundamentally change the findings it published in 2005. The interim report provides valuable information, however, about how HHS has implemented the recommendations from its 2005 report and outlines the additional steps that the agency is taking to preempt potential problems in the future.

In its 2005 report, HHS described four ways that the agency would move forward with regulation of specialty hospitals: reform the IPPS by refining DRGs; scrutinize more closely whether entities meet the definition of "hospital;" review procedures for approval and participation in Medicare (based on the revised definition); and reform payment rates for ASCs. In addition, and in response to critics who argued that specialty hospitals avoid their responsibility to care for the most vulnerable in the community, HHS indicated that it would also evaluate whether and how the Emergency Medical Treatment and Active Labor Act (EMTALA) should be applied to specialty hospitals. In general, EMTALA requires that a hospital "provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists."[13]

[13] 42 U.S.C. § 1395dd et seq.

Payment Reform: New Rule

The Deficit Reduction Act (signed February 8, 2006) mandated that HHS act on the 2005 report and develop a plan outlining how the agency would proceed with respect to specialty hospitals and the key issue of payment reform. HHS had already begun work on payment reforms, issuing a new IPPS payment rule in August 2005.[14] The new rule detailed changes to nine cardiac DRGs that, according to HHS, represented "a significant improvement in accuracy of the cardiac DRGs."[15] Changes outlined in the rule took effect on October 1, 2005.

HHS has also issued another proposed rule that would make additional changes to the IPPS in 2007 and 2008.[16] In its interim report, HHS explains that the objective is "to ensure that payment rates relate more closely to patient resource needs, thus reducing the advantages of selection of certain patients within DRGs by specialty hospitals," and that the "changes could have a significant effect across all hospitals."[17] The proposed rule contemplates changing the IPPS to better recognize differences in patient severity within DRGs and developing hospital-specific cost-based payment weights (as opposed to the current charge-based weights) to improve payment accuracy. (See page 8 of the 2005 RPC Policy Paper for greater discussion of this issue.)

Reforms to Ambulatory Surgical Center Payment Rates

Also in 2005, HHS noted that cardiac hospitals differ substantially from surgical and orthopedic hospitals in that "cardiac hospitals tend to have a higher average daily census, an emergency department, and other features, such as community outreach programs, while surgery and orthopedic hospitals more closely resemble ambulatory surgery centers, focusing primarily on outpatient services."[18] Accordingly, HHS recommended review of ASC payment rates in conjunction with the review of inpatient hospital payment rates. Under the current system for ASCs, nine basic payment rates are used to reimburse entities for approximately 2,500 distinct services, and payments differ drastically from those received for outpatient services performed in a hospital setting.[19] The interim report indicates that HHS intends to revise the list of procedures that are eligible for payment in ASCs – these changes would be effective as of July 1, 2007. One additional change to the ASC payment rate that is expected to take effect by the start of 2008 will involve removing most outpatient surgical procedures from the hospital payment system and reimbursing them at the same rate as if they were performed in an ASC.[20]

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[14] See 70 FR 47289-47292. The rule was published in the *Federal Register* on April 25, 2006, and comments were due by June 12.
[15] CMS Press Release, "CMS Announces FY 2006 Rate Increases for Inpatient Stays in Acute Care Hospitals," August 1, 2005.
[16] See 71 FR 23995-24472.
[17] HHS, "Strategic Plan Regarding Physician Investment in Specialty Hospitals: Section 5006 of the Deficit Reduction Act Interim Report," May 9, 2006, p.2.
[18] Mark McClellan, M.D., Administrator, Centers for Medicare & Medicaid Services (CMS), in testimony before the House Committee on Energy and Commerce, May 12, 2005 - http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1459, p.6.
[19] HHS, p.3.
[20] HHS, p.4.

The "Hospital" Definition Revisited

As noted above, many of the arguments against specialty hospitals revolve around whether these facilities meet the definition of "hospital" set forth in Section 1861(e) of the Social Security Act, or whether they simply replicate a single department or other subdivision of the whole hospital. The interim report makes an important statement with regard to this issue. HHS reiterates its previous finding that cardiac hospitals resemble full-service hospitals in many ways; however, the report goes one step further, noting that "even orthopedic and surgical specialty hospitals, which typically have far fewer beds than cardiac hospitals, are probably *no less engaged in furnishing care to hospital inpatients than are some community hospitals*, including some small rural hospitals."[21]

This statement is extremely important, since narrowing the definition of "hospital" to include certain required services (for example, an emergency department) would mean that some existing community hospitals would cease to be reimbursed as whole hospitals under Medicare. Instead, HHS indicates that it will continue to evaluate hospital applications for participation in Medicare on a case-by-case basis.[22]

Emergency Care and EMTALA

Another contentious issue relates to whether specialty hospitals avoid providing care to those on Medicaid (or those who cannot pay) by not seeing patients in an emergency care setting. In 2005, both HHS and MedPAC found that specialty hospitals cared for a lower percentage of Medicaid patients than did their community hospital competitors. The reports cited several reasons why this may be true, including the geographical differences amongst the hospitals studied and the differences in services rendered at those hospitals.

Congress, in the MMA, had directed HHS to form a technical advisory group to advise the Secretary on matters related to application of the EMTALA. The advisory group, known as the EMTALA TAG, was asked to consider three questions: whether all hospitals should be required to maintain an emergency department, whether EMTALA should be interpreted as requiring all hospitals with specialized capabilities or facilities to accept appropriate patient transfers, and whether specialty hospitals are exacerbating problems with "on-call" coverage within emergency departments.[23] For a variety of reasons, the EMTALA TAG, with support from groups including the American Hospital Association and the Federation of American Hospitals, recommended against requiring all hospitals to maintain emergency departments; however, it did recommend that all hospitals with specialized capabilities or facilities, including specialty hospitals, be required to accept appropriate transfers of unstable patients, regardless of whether that hospital has an emergency department.[24] The EMTALA TAG has not yet reached a conclusion on the issue of "on-call" coverage.

[21] HHS, p.4. (emphasis added)
[22] HHS, p.5. The report notes that HHS has denied provider agreements based on this type of review and has terminated existing agreements with entities that ceased to meet the definition.
[23] HHS, p.7.
[24] HHS, p.7.

Additional HHS Research to be Completed

Congress outlined additional concerns that related specifically to specialty hospitals. In particular, Congress asked HHS to collect information regarding the investment arrangements between specialty hospitals and their physician-owners. HHS reports that it has begun to analyze investment data supplied in connection with applications for provider agreements or as support for advisory opinions, but that additional data collection will be required. Specifically, HHS will be collecting information to assist in analyzing the proportionality of physician investment return and bona fide investment.[25] HHS will also be investigating whether the agency has the authority to require annual disclosure of physician investment information and to assess penalties for non-compliance. If HHS determines that it does not have such authority, the responsibility for regulating physician investment would fall to Congress.

In theory, each of the changes outlined above will contribute to creating a "level playing field" for *all* hospitals, whether by improving payment accuracy or by reducing disparate treatment of hospitals under the law.

Upcoming MedPAC Report Likely to be Consistent with Past Findings

Although MedPAC is not expected to release an updated report on specialty hospitals until later this year, the commissioners held a public meeting on April 19, 2006, that sheds some light on the conclusions they might draw. As with HHS, it is likely that MedPAC's findings will remain largely unchanged from last year. According to one MedPAC analyst at the meeting, "in general, our findings are similar to our prior findings, the difference being that the expanded set of data, covering two additional years of experience, allows us to have more confidence in the statistical significance of our findings."[26]

Length of Stay

In its March 2005 report, MedPAC indicated that patients in specialty hospitals typically had shorter lengths of stay than patients in community hospitals. One year later, MedPAC is noting that specialty hospital patients enjoy shorter than expected lengths of stay, with those differences being statistically significant when compared to other hospitals.[27] This is particularly significant due to the possibility of exposure to nosocomial (hospital-acquired) infection. Patients in specialty hospitals are less likely to be exposed to this type of infection as a result of the hospitals'specialized menu of services, and a shorter length of stay reduces the length of time that a patient may be exposed to infectious elements. Hospital-acquired infections lead to as many as 90,000 deaths each year, and treatment of these infections is estimated to increase overall health care expenditures by as much as $4.5 billion each year.[28]

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[25] HHS, p.8.
[26] Jeffrey Stensland, Ph.D., MedPAC analyst, in comments made during the MedPAC public meeting, April 19, 2006, p.104 – http://www.medpac.gov/public_meetings/transcripts/0406_allcombined_transc.pdf.
[27] Pettengill, p.110.
[28] "States Push to Disclose Hospital Infection Rates," Allison Aubrey, National Public Radio, May 11, 2006, available at http://www.npr.org/templates/story/story.php?storyId=5397454, and "Hospital-Acquired Infections," Quoc V. Nguyen, M.D., May 23, 2006, available at http://www.emedicine.com/ped/topic1619.htm.

Costs Associated with a Hospital Stay

The 2005 MedPAC report indicated that, although specialty hospitals were found to have shorter lengths of stay, the costs associated with each stay tended to be higher (although MedPAC did not consider the differences to be statistically significant).[29] MedPAC analysts noted that recent data regarding the cost per stay indicate that cardiac specialty hospitals' inpatient costs are similar to those in other hospitals, while costs associated with orthopedic and surgical hospitals remained higher than in other hospitals.[30] The reasons for this, MedPAC explains, may be twofold. First, since specialty hospitals, on the whole, tend to be new ventures, they may have higher capital costs: "this would make sense because new plants and equipment would generate higher depreciation and lease costs than older assets found in competing hospitals."[31] The second reason there may be differences in costs of stay relates to patient volume. According to MedPAC's analyst, "60 percent of the physician-owned orthopedic and surgical specialty hospitals have fewer than 20 beds, and more than 70 percent of them have [inpatient] occupancy rates under 35 percent."[32] This latter point provides insight as to why the costs in cardiac hospitals tend to be similar to those in community hospitals while orthopedic and surgical hospitals' costs tend to be somewhat higher.

Specialty Hospital Effects on Utilization

Another question that MedPAC sought to answer related to whether the presence of a specialty hospital in a given market led to increased utilization of services. At the public meeting, a MedPAC analyst stated that "historically, when physicians have invested in imaging centers or diagnostic labs, the physicians' investment was then often followed by an increase in utilization of the lab or imaging services."[33] It is unclear whether physician investment in heart hospitals would lead to higher utilization in procedures as invasive as cardiac surgery.

If physician profit were the only reason for investment in a cardiac specialty hospital, one would expect that utilization increases would be higher in markets where specialty hospitals were located. Yet, citing study data, the MedPAC analyst noted that "the ratio of more profitable, low-severity surgeries to less profitable, high-severity surgeries did not increase significantly faster in markets with physician-owned heart hospitals."[34] Although MedPAC would not rule out the possibility that financial incentives are having some effect on utilization, it also found that the magnitude of any shift toward more profitable surgeries is "too small to be detected with our tests of statistical significance."[35]

[29] Julian Pettengill, MedPAC analyst, in comments made during the MedPAC public meeting, April 19, 2006, p.108 – http://www.medpac.gov/public_meetings/transcripts/0406_allcombined_transc.pdf.
[30] Pettengill, p.110.
[31] Pettengill, p.111.
[32] Pettengill, p.111.
[33] Stensland, p.113.
[34] Stensland, p.114.
[35] Stensland, p.115.

Market Effects

An issue often tied to utilization is whether community hospitals' profit margins are adversely affected when specialty hospitals enter the market. MedPAC found that "the net result has been no statistically significant impact on the [community] hospitals' total revenue or total margins." Furthermore, "the median community hospital competing with heart hospitals had a total margin that was in line with the national average."[36] The reason this is so, according to MedPAC, is that its data showed that physicians tend to invest in hospitals that locate in growing markets. As such, "population growth has had a significantly positive effect on hospital profit margins, but the competition from physician-owned specialty hospitals has not."[37]

GAO Report: Another Look at Market Effects

House Ways and Means Committee Chairman Bill Thomas asked GAO to study the competitive response of community hospitals to specialty hospitals' entrance into the marketplace. In a report issued in April 2006, GAO found that most of the hospitals it surveyed had made "operational and clinical service changes to remain competitive in what they viewed as increasingly competitive healthcare markets."[38] GAO found no evidence, however, to support the idea that the presence of a specialty hospital in the marketplace had a significant effect on the number or types of changes made by community hospitals.[39]

GAO does note that, while MedPAC and others have acknowledged efforts in community hospitals to "expand other sources of revenue" or otherwise compensate for any business that may be lost to specialty hospitals, its own data do not support this theory.[40] GAO states that "to date, there have been only anecdotal reports of how general hospitals have competitively responded to specialty hospitals."[41] Furthermore, "general hospitals face competition from many types of facilities, not just specialty hospitals. Competing facilities, including other general hospitals in the market, ASCs, and imaging centers, far outnumber the relatively few specialty hospitals in existence or under development."[42]

These results, coupled with MedPAC's finding that the profit margins of community hospitals in the same market as specialty hospitals are not appreciably different than those of other community hospitals, would seem to indicate that any decrease in profitability in community hospitals can be attributed, not to specialty hospitals specifically, but to a general inability of a particular hospital to respond to increased competition.

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[36] Stensland, p.116.
[37] Stensland, p.116.
[38] GAO, "General Hospitals: Operational and Clinical Changes Largely Unaffected by Presence of Competing Specialty Hospitals," Report to the Chairman, Committee on Ways and Means, House of Representatives, April 2006, p.4.
[39] GAO, p.4.
[40] See, for example, Stensland, p.116.
[41] GAO, p.8.
[42] GAO, p.20.

Community Hospitals' Concerns Persist

The Senate Finance Committee recently invited representatives from both community hospitals and specialty hospitals to testify about the impact of physician-owned specialty hospitals on their surrounding communities. At the May 17, 2006, hearing, committee members heard testimony from the Coalition of Full Service Hospitals (representing community hospitals) and the American Surgical Hospital Association (representing specialty hospitals).

The Coalition of Full Service Hospitals testified that "the financial realization that comes from [physician] self-referral is too powerful to be overcome by DRG changes alone."[43] Instead, the Coalition suggested that specialty hospitals should not be recognized as whole hospitals, in keeping with the "letter and spirit of the current self-referral laws."[44] The Coalition reiterated its concern that "community hospitals play a special role in both urban and rural communities as 'equal opportunity' caregivers that provide full acute and sub-acute services without discrimination based on insurance status or seriousness of condition," while "specialty hospitals, by contrast, choose to provide only limited, high-revenue services to select, usually well-insured, patients."[45]

The American Surgical Hospital Association (ASHA) countered, noting that "despite the vitriol directed at specialty hospitals by competitors and other hospital trade groups, joint ventures between physician-owned specialty hospitals and community hospitals are common."[46] Furthermore, ASHA noted that GAO, in a 2003 report on specialty hospitals, found that "approximately one-third of identified specialty hospitals had a general hospital partner."[47] ASHA closed its testimony by stating "it has been firmly established that our members provide high quality medical care, equal or superior to the best that general hospitals have to offer."[48]

Conclusion

The purpose of the MMA moratorium and its subsequent extensions was to allow ample time for Congress to study the impact specialty hospitals have on competing community hospitals. While opponents of specialty hospitals contended that the 2005 reports were based on insufficient data, and that a second round of studies would uncover larger, more dire problems, this has not proven to be the case.

Reviews of recent data do not indicate that specialty hospitals are currently posing harm to community hospitals. HHS is taking administrative action toward ensuring that *all* hospitals are able to compete on a level playing field, and that regulatory actions do not disproportionately

[43] Cindy Morrison (on behalf of the Coalition of Full Service Hospitals) in testimony before the Senate Finance Committee, May 17, 2006.
[44] Morrison.
[45] Morrison.
[46] John House, M.D., (on behalf of the American Surgical Hospital Association) in testimony before the Senate Finance Committee, May 17, 2006.
[47] House.
[48] House.

affect any one type of hospital. Many different types of providers have a role to play in delivering quality care; the nation's teaching hospitals, in particular, are places that foster innovation and educate the next generation of medical providers. Although community hospitals point to specialty hospitals as a problem that needs to be more tightly controlled, data suggest that specialty hospitals, too, have a role to play in the delivery of high quality care.

Meanwhile, Congress has an ongoing oversight responsibility to ensure that federal health care dollars are used wisely and that communities nationwide are receiving the highest quality care. As such, Congress can and should continue to monitor this issue to ensure that the end result is stronger hospitals across-the-board. Hospitals should be allowed to focus on the quality of care they provide to patients without being distracted by concerns about whether that care will be fairly and adequately reimbursed.

Attachment: *The Specialty Hospital Debate: Beyond the Medicare Moratorium*, May 23, 2005

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Executive Summary

- On June 8, an 18-month moratorium imposed on certain specialty hospitals that serve Medicare patients will expire.
- The rationale for the moratorium was to address concerns voiced by traditional community hospitals that the competition posed by physician-owned specialty hospitals would hurt their ability to offer quality care to all of their patients.
- Specifically, the moratorium is on the referral of Medicare patients to new, physician-owned specialty hospitals (particularly those specializing in cardiac, orthopedic, and surgical care).
- To help it determine the impact specialty hospitals have on overall patient care, Congress mandated studies by the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS). Both studies were due March 8, 2005.
- In its report to Congress, MedPAC recommended reforms to the payment system used to reimburse hospitals for Medicare patients in order to make the system more fair. MedPAC estimated that its reforms would substantially benefit many community hospitals. MedPAC also suggested that the moratorium be extended for an additional 18 months.
- Importantly, the MedPAC report did not base its moratorium extension recommendation on a finding of financial harm to the community hospitals as a result of competition from the specialty hospitals. Indeed, it produced no evidence of such harm. Rather, it suggested that the moratorium be extended only for the purpose of allowing both Congress and the Secretary of HHS time to consider and implement its payment-reform recommendations.
- In its report, CMS also recommended reform of the Medicare payment system and called for a six-month study period to allow time to begin implementation of the reforms.
- Based on the current lack of evidence of harm from specialty hospitals, extension of the moratorium is not warranted. However, it would be beneficial to the community hospitals, in particular, for Congress to implement payment reforms along the lines of those recommended by MedPAC and CMS. This is the more appropriate response to the concerns raised by the community hospitals than an extension of the moratorium, and is more likely to result in achieving the paramount goal of assuring quality health care for all Americans.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), well known for its historic reforms to the Medicare program, contained a little-known provision imposing an 18-month moratorium on the referral of Medicare patients to new, physician-owned "specialty hospitals." That moratorium is set to expire on June 8, 2005.[1]

Specialized, targeted-care facilities, like women's and children's hospitals, are not new to medicine. However, the recent, rapid growth of certain specialized facilities owned by physicians represents a relatively new trend. What the MMA identified for scrutiny were those specialty hospitals that primarily provide care to Medicare patients in one of three areas: cardiac care, orthopedics, or surgery.[2] Concerns about how the success of these facilities might affect the financial well-being of community hospitals prompted Congress to impose the moratorium. The intent of the Congress was to determine whether additional legislative or administrative restrictions on specialty hospitals were necessary, pending a review of the issue by the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS).[3]

As the June 8 expiration date approaches, Congress must decide whether to extend the moratorium or allow it to expire. This paper examines the information available to Congress in making its decision, and compares the arguments for and against extending the moratorium.

Meanwhile, there is justification for the Senate to work on a related matter: reform of the Medicare payment system for hospitals. Improving the fairness in the way that Medicare pays hospitals will ensure that both community hospitals and specialty hospitals receive adequate and appropriate payment for their services, which is key to preserving quality care for Medicare patients. This in turn will assure that hospitals can continue to adequately serve the entire community.

Background

Proponents of physician-owned specialty hospitals argue that the recent increase in the number of such facilities grew out of physicians' frustrations with community hospital administration and the physicians' desire to provide better care for their patients, increase predictability in scheduling of patient procedures, and have greater administrative control over

[1]Section 507 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173, H.R. 1, 108th Congress, 1st Session, December 8, 2003 (hereafter referred to as MMA).

[2]MMA, Section 507(a)(1)(B).

[3]MMA, Section 507(c).

the management of their cases.[4] Opponents of specialty hospitals counter that physicians' true motivation is "self-interest and profit."[5]

During the 2003 debate on Medicare reform, representatives of the nation's traditional community hospitals voiced concerns about increased competition from physician-owned specialty hospitals, asserting that physicians could refer the most profitable cases to facilities in which they have an ownership interest. Community hospitals, of course, treat all kinds of patients at all levels of care, not all of them highly profitable. As such, they have employed the practice of "cross-subsidizing" – allowing the use of higher-profit services to offset the costs of less profitable but necessary services, like burn units and trauma centers.[6] They contended that the loss of some of the more profitable services to specialty hospitals would substantially affect their ability to maintain critical but unprofitable services. As a result, Congress imposed the 18-month moratorium on referral of Medicare patients to physician-owned cardiac, orthopedic, and surgical hospitals that were not in existence as of November 18, 2003.[7]

To help it determine what, if any, detrimental effects these specialty hospitals have on the traditional hospitals operating in the same communities, Congress also mandated reports from two federal agencies, MedPAC and HHS.[8] MedPAC was ordered to primarily study the financial impact, while HHS was ordered to study the issue primarily from a quality-of-care perspective. MedPAC is an independent federal body permanently charged with the task of making Medicare payment-policy recommendations to Congress twice each year (in addition to issuing special reports, such as the one mandated by MMA). The HHS study was conducted by the Centers for Medicare and Medicaid Services (CMS), which under the direction of the Secretary of HHS, is charged with administering both the Medicare and Medicaid programs.

In its efforts to discover whether specialty hospitals threaten the viability of community hospitals, Congress mandated that each agency report to Congress on certain specified topics. For example, MedPAC was directed to focus its efforts on examining the current system used to reimburse hospitals for inpatient stays. CMS was directed to focus on patient referral patterns, quality of care, and differences in uncompensated care. Both studies, including each group's recommendations for legislation or administrative changes, were due to Congress by March 8, 2005. This was meant to provide Congress with ample time to consider the findings and make a fair determination as to the best way to respond to the concerns of both hospital groups prior to the expiration of the moratorium.

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[4]Jamie Harris, Executive Vice President and Chief Financial Officer, MedCath Corporation, in testimony before the House Committee on Ways and Means, March 8, 2005 - http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2533, and MedPAC, "MedPAC Report to the Congress: Physician-Owned Specialty Hospitals," March 2005, p.vii.

[5]Dick Davidson, "Hospitals Competing for Patients," op-ed, *The Washington Times*, January 28, 2005, p.A18.

[6]American Hospital Association, *TrendWatch*, September 2004, p.7.

[7]MMA, Section 507(a)(1)(B).

[8]Although CMS was asked to look primarily at quality of care issues, the MMA did give CMS the task of "assess[ing] the differences in uncompensated care ... and the relative value of any tax exemption available to such hospitals," MMA, Section 507(c)(2)(D).

Study Results Form the Core of the Issue

What the Studies Found

With expiration of the moratorium on Medicare referrals imminent, traditional hospitals are asking Congress to extend it. Specialty hospitals, on the other hand, claim that their ability to grow in the marketplace and, therefore, better serve Medicare patients, has been stifled long enough, and are asking Congress to allow the moratorium to expire.

In keeping with its intent to determine if restrictions in the hospital marketplace are appropriate, Congress should study the reports to consider whether there is evidence of harm and analyze the accompanying recommendations. MedPAC submitted its report to Congress on time, on March 8, while the CMS report was only made available on May 12. It is important to note from the outset that neither report provides evidence that the operations of specialty hospitals pose harm to community hospitals.[9]

MedPAC's Findings on Harm

In preparation to study whether specialty hospitals are harming the financial health of community hospitals, MedPAC articulated four criteria for determining which specialty hospitals to include in its study in order to produce reliable results.[10] To be included, MedPAC required that the hospital be physician-owned, specialize in a particular category of services (for example, cardiac) and offer at least two major procedures in that category as part of its menu of services, have a minimum of at least 25 Medicare cases during 2002, and have submitted Medicare cost reports and claims for 2002.[11] Of the nearly 100 specialty hospitals operating nationwide, 48 met all of the MedPAC criteria. The remaining specialty hospitals, according to MedPAC, could not provide sufficient data because they opened after 2002 or were still under construction.[12]

To supplement its review of the cost reports and claims data for the 48 selected specialty hospitals, the agency made site visits to three markets, where it conducted interviews with representatives from eight specialty hospitals and nine community hospitals. Additional information was obtained through conversations with an additional group of 14 specialty hospitals and seven community hospitals.[13]

After analysis, MedPAC put forward no conclusive data that there is any financial harm to community hospitals as a result of the operation of specialty hospitals. The report states, "The financial impact on community hospitals in the markets in which physician-owned specialty

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[9]See Footnote 4 and CMS, "Centers for Medicare & Medicaid Services Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," May 2005.

[10]MedPAC, p.4.

[11]MedPAC, p.4. Note that 2002 was the most recent set of complete Medicare costs and claims data available for review at the time that MedPAC undertook its study.

[12]MedPAC, p.4.

[13]MedPAC, p.5.

hospitals are located has been limited, thus far. Those community hospitals competing with specialty hospitals have demonstrated financial performance comparable to other community hospitals."[14] The report underscored this in noting that there had been "little impact on community-hospital profitability" during the period studied by MedPAC.[15] Moreover, it suggests that "specialty hospitals may be an important competitive force that promotes innovation."[16]

CMS's Findings on Harm

CMS used similar criteria to define its sample of study hospitals, although it required that, to be included, the hospital offer five major procedures in its category of specialization.[17] The agency further required that the hospitals be geographically diverse (i.e., include both urban and rural hospitals), include both mature hospitals and recent start-ups (to understand the evolution of the industry), and have adequate caseloads to facilitate analysis and the use of patient focus groups.[18] Applying the criteria, CMS reached a study sample of 11 specialty hospitals in six markets to which site visits were made. CMS also made visits to competing community hospitals in each of the six markets.[19] Data from the site visits was supplemented with analysis of cost reports and claims data for all specialty hospitals and their competitors through 2003.[20]

In contrast to a finding of harm, Dr. Mark McClellan, Administrator of CMS, remarked on findings of high quality of care at the specialty hospitals studied by CMS when he presented his agency's report to Congress. With regard to patient care, he noted that "specialty hospitals generally provide a more uniform set of services and have fewer competing pressures than community hospitals, and thus are able to provide more predictable scheduling and patient care."[21] The CMS report also found fewer complications and lower mortality rates at cardiac hospitals, even when adjusted for severity, and remarked that "cardiac hospitals delivered high quality of care that was as good as or better than their competitor hospitals."[22] As for surgical and orthopedic hospitals, CMS remarked that, although smaller sample sizes precluded the agency from drawing statistically significant conclusions on the quality of care in these facilities, patient satisfaction was extremely high.[23]

The Question of the Moratorium

Despite having found no evidence of harm, MedPAC recommended that Congress extend the moratorium for an additional 18 months. This recommendation seems to be based on a new

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[14]MedPAC, p.vii.
[15]MedPAC, p.23.
[16]MedPAC, p.43.
[17]CMS, p.5.
[18]CMS, p.6.
[19]CMS, p.6.
[20]CMS, p.8.
[21]Mark McClellan, M.D., Administrator, Centers for Medicare & Medicaid Services (CMS), in testimony before the House Committee on Energy and Commerce, May 12, 2005 - http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1459.
[22]CMS, p.42 and p.iii.
[23]CMS, p.iii

argument, that implementation of payment reforms – which MedPAC, in this same report, recommends – should begin before specialty hospitals are allowed to re-enter the marketplace. MedPAC's suggested reforms would significantly change the way that hospitals are reimbursed for Medicare inpatients. (These recommended reforms are detailed in the next section of this paper.) The report states that an extension is needed to allow additional time for gathering information, and to provide Congress time to consider the complex payment reform recommendations that it details and give HHS time to implement them.[24] It is unclear why, as MedPAC seems to say, it is justifiable to penalize the specialty hospitals while payment reforms for all hospitals are being implemented. In any event, this rationale for extension is not consistent with the original intent of Congress, which was to impose a temporary moratorium while awaiting MedPAC's and CMS's reports on harm.

Further, MedPAC suggests that, in order to spare hospitals from incurring drastic, one-time changes in reimbursement rates that might result if its payment reform recommendations were implemented, the reform process should be conducted incrementally over a transitional period. The report, however, gives no clear indication of how long a period would be needed.[25] It is unlikely that Congress and HHS can design and implement large-scale reforms in only 18 months. If it adhered to its new rationale, in January 2007, MedPAC presumably would again advocate extension of the moratorium until payment reforms are complete. Thus, instead of resolving Congress' questions about the effect of specialty hospitals, this recommendation leaves Congress with an indefinite timeline, and precludes further study of this fledgling sector of the hospital industry.

CMS does not recommend a moratorium, but does suggest a review period, during which the agency will review is Medicare participant approval procedures for hospitals.[26] The agency suggests that its review of participant approval procedures could take up to six months, during which time CMS "will instruct [its] fiscal intermediaries to refrain from processing further participation applications from specialty hospitals."[27] When questioned by members of the Energy and Commerce Committee about whether this six-month review constitutes a moratorium, Dr. McClellan was emphatic in stating that CMS does not support extension of the current moratorium.[28]

Beyond the Moratorium: Medicare Payment Reforms

MedPAC's Recommendations

MedPAC's remaining recommendations in its report to Congress relate to improving payment accuracy in the Medicare Inpatient Prospective Payment System (IPPS). Thus, MedPAC is clearly focusing much more on the proactive – payment reforms – than on the

[24]MedPAC, p.43.
[25]MedPAC, p.viii.
[26]McClellan, p.10.
[27]McClellan, p.20.
[28]Mark McClellan, M.D., Administrator, Centers for Medicare & Medicaid Services (CMS), during questioning by the House Committee on Energy and Commerce, May 12, 2005.

punitive – extension of the moratorium. This is an appropriate focus because payment reforms will affect all types of hospitals. As MedPAC Chairman Glenn Hackbarth commented, "What's striking to me is that ... this is an issue not just in specialty hospitals but really across the hospital sector, not-for-profit, for-profit, specialty, general hospital. This is a more fundamental issue."[29]

Specifically, MedPAC focuses on a reform that can eliminate disparities and equalize payments to all inpatient hospitals: refining the current diagnosis-related groups, known as DRGs, which are used in determining payment to hospitals for inpatient stays.[30] DRGs are used to classify Medicare hospital inpatients for payment purposes, based on their medical diagnosis and the procedures that will be performed during their stay; the DRGs are then used as part of a complex, multi-factor payment formula to determine how much a hospital will be reimbursed for care of a particular patient. One of the problems identified by MedPAC is that some DRGs are defined very broadly and often include patients who receive the same general diagnosis but whose conditions differ greatly in terms of severity. Thus, although admission of a very sick patient requires that a hospital spend more money during the course of treatment than for the admission of a healthier patient, the hospital currently receives the same reimbursement from Medicare if the two patients' general diagnosis is the same.

MedPAC revealed a critical fault with the current system that is at the heart of the moratorium debate. That is, that the current payment system encourages "cherry-picking" (i.e., patient selection based on profitability). According to MedPAC, "Discrepancies between Medicare's payment rates and hospitals' average costs per discharge across DRGs result in differences in profitability. These profitability differences create financial incentives – for all hospitals, *specialty and nonspecialty alike* – to specialize in treating relatively profitable DRGs."[31] MedPAC further notes that "when DRGs are defined too broadly they fail to isolate differences in severity of illness that substantially affect the cost of hospital inpatient care. The resulting differences in profitability *within* DRGs create financial incentives for hospitals to select relatively low-cost patients, such as those who have the same diagnosis but are less severely ill."[32]

Part of the reason that this fault is critical is that the hospital inpatient payment system is prospective, meaning that hospitals receive a predetermined amount per patient, based on the DRG formulation described above. The reimbursement amount is intended to cover the *expected* costs of treating that patient; however, some providers will be paid somewhat more than their actual costs and many will be paid somewhat less.

MedPAC wants to address this critical fault by refining the DRGs to reflect more accurately differences in the severity of patient illnesses, thereby reducing the opportunity for adverse patient selection. In the current system, a single DRG encompasses several degrees of

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[29]Glenn M. Hackbarth, in comments made during the MedPAC public meeting, October 29, 2004, p.331 - http://www.medpac.gov/public_meetings/transcripts/1004_allcombined_transcript.pdf.

[30]MedPAC, p.viii.

[31]MedPAC, p.25 (emphasis added).

[32]MedPAC, p.26 (emphasis added).

patient severity, but what MedPAC recommends is a refined DRG system that would have multiple DRGs for a single diagnosis, with each DRG representing a different level of patient severity. Hospital reimbursements would reflect these refinements, with hospitals receiving increased payments for more severe cases. As MedPAC notes, refinements in the DRG system will certainly mean that some providers will see an increase in payments, while others will see a decrease in payments, depending on the patients they see. Overall, however, MedPAC argues that the refinements will result in a more equitable reimbursement system that will not require additional federal spending and will not affect patient access to care.[33]

Additional MedPAC recommendations touch on another element of the complex hospital payment formula: DRG relative weights. MedPAC suggests that these weights, or payment factors, be based on the *estimated cost of care* rather than on the average of national *charges*. Under the current system, "CMS assigns a relative weight to each DRG that is intended to reflect the relative costliness of typical patients in that [DRG] compared with the cost of treating the average Medicare patient."[34] To compute the relative costliness of the patient, CMS looks at the national average of charges that hospitals bill to Medicare for each DRG. However, due to differences in hospital charges, this number may not reflect the actual cost of care. There are several factors that may influence the way a hospital bills Medicare for its patients' care. One example cited by MedPAC is that hospital markups for ancillary services, like access to the operating room or imaging services, tend to be higher than markups for routine services like room and board. Thus, weights for DRGs that typically require significant use of ancillary services will, over time, become higher in comparison to the actual cost of care. Conversely, weights for DRGs using primarily routine services may not be high enough.[35]

MedPAC recommends that the relative weights be based on the estimated cost of care, so that hospital markups on services would equalize in order to prevent under-reimbursement. As with refinement of DRGs, MedPAC contends that changes in the relative weights that more accurately reflect the cost of care within each DRG will lead to more equitable reimbursement and will not require additional federal spending and will not affect patient access to care.[36]

CMS's Recommendations

Three of CMS's four recommendations, which provide for payment reforms as well as administrative changes to the Medicare program, are based on a distinction that CMS draws between the average cardiac hospital and its surgical and orthopedic counterparts.

This distinction is important because, although many of CMS's findings applied generally to all specialty hospitals, the CMS report notes that cardiac hospitals differ substantially from surgical and orthopedic hospitals in that "cardiac hospitals tend to have a higher average daily census, an emergency department, and other features, such as community outreach programs, while surgery and orthopedic hospitals more closely resemble ambulatory surgery centers,

[33]MedPAC, p.40.
[34]MedPAC, p.28.
[35]MedPAC, p.26.
[36]MedPAC, p.40.

focusing primarily on outpatient services."[37] Thus, CMS drew upon information it gathered in response to a separate mandate related to ambulatory surgery centers (ASCs) in formulating a response on the issue of specialty hospitals.[38] CMS concludes that reforms are needed for both inpatient hospital stays and for ASC services.

In the two months since MedPAC issued its report to Congress, CMS has begun the process of analyzing MedPAC's recommendations to assess the feasibility of implementing the suggested payment reforms and determine how the reforms might impact hospitals.[39] Using the MedPAC report as a guide, CMS plans to implement significant reforms to the Medicare inpatient payment system; however, CMS suggests that other irregularities in hospital payment policy may exist, and that refinement of the inpatient payment system is only the first step in assuring that all hospitals are paid accurately for the services they provide. Through its research, CMS determined that, while cardiac hospitals tend to be similar to community hospitals, orthopedic and surgical hospitals more closely resemble ASCs. Thus, CMS suggested, "physicians may be participating in the ownership of small orthopedic or surgical hospitals rather than in ASCs in part to take advantage of payment differences between hospital outpatient departments and ASCs."[40] Because the current ASC payment system is badly outdated, "the payments for particular services are [often] significantly higher in hospital outpatient departments" than in ASCs.[41] These differences, CMS reasons, create incentives for physicians to develop orthopedic and surgical hospitals where services are reimbursed at higher rates. Reforming the ASC payment system will eliminate these payment differences.

In order to complement the above-mentioned payment reforms, CMS recommends "closer scrutiny of whether entities meet the definition of a hospital" under Section 1861(e) of the Social Security Act.[42] One of the key requirements for a hospital under Section 1861(e) is that it be primarily engaged in treating patients in an inpatient setting. If CMS implements its recommendation, any entity that does not meet the Section 1861(e) definition of "hospital" will be ineligible for a Medicare hospital provider agreement.[43] CMS makes it clear that this requirement will apply to both new applications and existing provider agreements; if a hospital ceases to be engaged primarily in inpatient care, the hospital's provider agreement may be terminated. Thus, those specialty hospitals whose patient populations consist primarily of outpatients will not be granted Medicare hospital provider agreements but will likely be categorized instead as ASCs and will be reimbursed accordingly.

Effects of the Recommendations

The MedPAC report provided an analysis of how the agency anticipated that its suggested payment reforms might affect community and specialty hospitals. According to the report, both

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[37]McClellan, p.6.
[38]MMA, Section 626.
[39]McClellan, p.10.
[40]McClellan, p.17.
[41]McClellan, p.17.
[42]McClellan, p.18. See also 42 U.S.C. 1395x.
[43]McClellan, p.18.

types of hospitals would see payment increases in some areas and payment decreases in others, if all of the MedPAC payment reforms were implemented. It is important to note MedPAC's conclusion that, while some community hospitals would see a decline in payment amounts, many more would see payment increases.[44] Moreover, MedPAC found that nearly all specialty hospitals would see decreases in their payments, and that no specialty hospitals are projected to receive increased payments. Even so, specialty hospital proponents continue to support payment reform as a means of allaying the concerns of specialty hospital detractors.[45]

In its recommendations, CMS concurs with MedPAC's recommendation that improving the accuracy of IPPS payment rates would be worthwhile. CMS finds that, while "the emergence of specialty hospitals makes pointed the need for such improvement, we believe such changes should be desirable in any case."[46] The agency cautions that, while payment reforms are needed, it is still conducting a detailed analysis of MedPAC's recommended reforms and their possible effects on patient care. CMS further cautions that, even with reforms, any reimbursement system "that groups cases and provides a standard payment for cases in the group – that is, the IPPS among other Medicare payment systems – will always present some opportunities for providers to specialize in cases where they believe margins are better."[47] The report concludes that improving payment accuracy should reduce opportunities and incentives for achieving profitability through adverse patient selection.[48]

Senate Response

In anticipation of the moratorium's expiration, Senator Charles Grassley, Chairman of the Senate Committee on Finance, recently introduced legislation that would implement MedPAC's recommended payment reforms.[49] However, the legislation would also make *permanent* the moratorium on new specialty hospitals, while the operations of existing specialty hospitals would essentially be frozen.[50] In short, the bill would foreclose any possibility of further growth of the physician-owned specialty hospital industry.

Neither MedPAC nor CMS has advocated a permanent moratorium. To the contrary, both agencies have indicated that specialty hospitals represent a desirable, alternative form of

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[44]MedPAC, p.39.

[45]Alan Pierrot, M.D., Past President, American Surgical Hospital Association, in testimony before the Senate Committee on Finance, March 8, 2005 - http://finance.senate.gov/hearings/testimony/2005test/030805aptest.pdf, and Michael Maves, M.D., Executive Vice President, American Medical Association, in a letter to Senate Majority Leader Bill Frist, April 22, 2005.

[46]CMS, Recommendations Regarding Physician-Owned Specialty Hospitals, May 2005 - http://www.cms.hhs.gov/media/press/files/052005/RecommendationsRegardingPhysicianOwnedSpecialtyHospitals.pdf.

[47]CMS Recommendations.

[48]CMS Recommendations.

[49]"Hospital Fair Competition Act of 2005," S. 1002, 109th Congress, 1st Session.

[50]Current Law and Section-by-Section Analysis of the "Hospital Fair Competition Act of 2005," distributed by the Senate Committee on Finance. According to the document, existing specialty hospitals "would be prohibited from increasing their number of physician investors, increasing the percent of individual investment and aggregate physician investment in the facility, expanding their scope of services, and increasing their number of beds or operating rooms."

care for many Medicare patients and agree that specialty hospitals should be permitted to operate, provided that concerns about payment inequalities are alleviated.

Taken together, the payment recommendations of MedPAC and CMS provide a road map for reform of the Medicare payment system and suggest administrative action that would enhance the effectiveness of such reforms, making extension of the current moratorium unnecessary.

Conclusion

Congress' asserted power to legislate that certain businesses cannot participate in federal health programs must be exercised carefully. In determining whether to extend the specialty hospital moratorium or allow it to expire, Congress should consider the evidence it has before it. General hospitals continue to argue that they are disadvantaged by the operation of specialty hospitals. Specialty hospitals respond that there is insufficient data to conclude that their operations are having a detrimental effect on traditional community hospitals or on inpatient care, and that, based on the reports of MedPAC and CMS, extension of the moratorium is unwarranted.

Medicare payment reform provides a possible solution that will address the concerns that prompted the moratorium, ensuring that, whatever the past impacts, both community and specialty hospitals can be paid fairly for the services they provide.